PRESIDENTIAL ADDRESS ON THE RESPONSIBILITIES OF THE MEDICAL ATTENDANT

IN OBSTETRICAL AND GYNÆCOLOGICAL CASES.

Delivered before the Edinburgh Obstetrical Society,

By ALEXANDER BALLANTYNE, M.D.,

Eskbank, Midlothian, N.B.

In commencing his valedictory Presidential address Dr. Ballantyne said that during his term of office two honorary Fellows, two corresponding Fellows, and twelve ordinary Fellows had been removed by death. Just two years ago the Society was made poorer by the death of Dr. George Battey, of Rome, Georgia, whose name will remain notable as long as gynæcology exists. The President glanced briefly at Battey's connection with ovariectomy, reminded the Society that he had emphatically stated that the operation should only be done as a *dernier ressort*. "This much," he said, "is due to the dignity of our calling; this much is due to humanity, to decency, and to public morality." Battey was a guest at the Society's meeting in July, 1881, when he detailed a case of extrauterine pregnancy on which he had operated. The work of Marion Sims and Lawson Tait had placed the safety and utility of ovariectomy beyond a doubt. The name of another honorary Fellow and of a still greater gynæcologist than Battey also appeared in the death list, namely, Sir Thomas Spencer Wells. Before 1858, when Wells did his first completed ovariectomy, Clay in England beginning in 1842, and the two Atlees in America (John in 1843, and his more famous brother Washington in 1844) had continued in the face of all opposition to carry on an unchecked career of operating as suitable cases presented themselves. The all-important part which Clay had played in the advancement of ovariectomy was referred to, and subsequently the work and career of Spencer Wells. It was during the Crimean War that the latter learned "that a man's abdominal walls might be lacerated by fragments of shell, his intestines protruding and covered with mud, so remaining for several hours, and yet, after careful cleansing of the cavity and accurate closure of the wounds, complete recovery was possible, which," he added, "made him much less afraid of abdominal wounds." It might be doubted whether the revival of ovariectomy under the influence of Clay and Wells would have been so complete but for the third strong-siding champion, Thomas Keith, who began operating in 1862, and whose altogether marvellous results were, according to Sims, "the wonder and admiration of surgeons all over the world."

Obstetrics had suffered more than gynæcology by the deaths of Dr. Kidd (Dublin), Dr. Lusk (New York), Dr. Pajot (Paris), Dr. Stadtfeldt (Copenhagen), and Dr. Braxton Hicks (London) all exceptionally able teachers and writers. During Dr. Ballantyne's presidency, while there was an abiding sense of loss, the places of those who had gone were being filled by others well fitted to carry on the work of the Society. Thirty-five ordinary Fellows had been elected during the period in question, making the number 402 at present, which, with 35 honorary Fellows and 86 corresponding Fellows, brought the membership up to 523, precisely the number two years ago. The work done at the ordinary meetings of the Society during its 57th and 58th sessions was then referred to. From this the President passed to a consideration of certain ethical questions which had been under consideration at the last meeting of the 57th session. He said:

It is not my intention to give a summary of the various opinions expressed, nor even to state what direction discussion took (for this you can recall as easily as I can), but to endeavour to ascertain what relation obstetricians and gynæcologists stand to the law chiefly on the question of professional secrecy. It is granted on all hands that there is much that is uncertain and much that is unsatisfactory regarding this matter, and that not only medical men but

lawyers differ as to when and under what circumstances it becomes the duty of the medical adviser to break faith with his patient.

Theoretically, of course, the doctor is constantly under the Hippocratic oath—that facts, medical or otherwise, which a practitioner learns from his patient during professional attendance should not be divulged. And the law of this country seems clearly to hold that a secret acquired by a medical man during his attendance upon a patient is the secret of the patient, and therefore that he or she has a *prima facie* right in law to require that his or her secret should be kept, unless it can be shown that there is some paramount reason setting aside that right. The law, then, so far upholds our old professional rule.

Individual judges have from time to time gone even further, and have indicated that medical men should legally be under this ancient rule, with certain exceptions. Thus Mr. Justice Buller expressed his regret that the information got from medical men was not privileged. Lord Brougham expressed himself in much the same way, and Chief Justice Best said that the law was hard in itself, of questionable policy, and contrary to that of America and France.¹ While Mr. Justice Hawkins, in the comparatively recent case of *Kitson v. Playfair and wife*, said that there were criminal cases—and he instanced one, that of self-inflicted criminal abortion—where it would be "monstrous cruelty" for the doctor to inform the police "and with regard to those when it was said the doctor should inform, the judge might himself in some cases refuse to commit a medical man for contempt in refusing to reveal confidences." From this it is evident that there are many cases occurring in medical practice in which a practitioner may be in serious doubt whether he should inform the Public Prosecutor, and about which any judge, in the event of the information being given, may express his own individual opinion, adverse or otherwise, as circumstances presented themselves to his mind during a trial.

In America and France the law differs from that of this country in so far that it binds the doctor to keep his patient's secret. In America the law binds the professions of the Church, Law, and Medicine equally. According to this legal code, "the clergyman is prevented from disclosing confessions made to him in his professional character in the course of discipline enjoined by the rules of practice of the religious body to which he belongs. The attorney or counsellor at law is not allowed to disclose a communication made by his client to him, or his advice given thereon in the course of his professional employment. And a person qualified to practise physic or surgery is not allowed to disclose any information which he acquired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity." From this it is plain that in America the three professions stand in precisely the same relationship to those seeking their counsel and advice. The law recognises that a certain portion of the community has from circumstances been placed at disadvantage and is suffering in some way in relation to religion, law, or medicine, that it needs help from some one of these professions, and that it would be wrong to place any obstacle in the way of obtaining it, whether guilty or innocent. The penitent is safe with the priest, the suspected criminal is safe with his attorney and counsel, and the patient is, or should be, safe with his medical adviser. The members of each profession get necessary information for a special and humane purpose—information they would certainly not have acquired had the simple benefit to the person not been the sole end in view, and which probably would have been withheld but for the seal of professional confidence. And the revisers of the American code even go further by stating that the necessity of the law relating to medical men is even stronger than in the case of a legal adviser when life itself may be in danger. And yet the law which binds a physician to secrecy is very frequently broken by the ruling of its administrators. Thus Judge Bartlett, speaking on the subject of criminal abortion at a meeting of a medical society presided over by Dr. Joseph H. Raymond, said: "The rule may be regarded as pretty well settled in this State that the physician is compellable by law to disclose (in the witness box, not voluntarily) what he knows indicating the commission of criminal abortion where the victim of that abortion is dead. Where the patient, how-

ever, survives and does not waive her privilege, the medical practitioner must keep silence."

And District Attorney Backus speaking at the same meeting on the same subject gave it as his opinion that a self-attempted abortion should not be disclosed whether the person lived or died; but where it is done by another, the doctor should endeavour to procure the consent of the patient to inform even though she survives. It is quite evident from these opinions and from cases constantly occurring in American law courts that while the three professions are almost exactly word for word bound under the same law, the medical profession alone is compelled by law to break the law that binds them. Whether this be right is open to question. It is difficult to see in what way the doctor differs from the lawyer and the clergyman. Under this law the silence of the medical man cannot be looked upon as concealing a crime; and surely his reticence defeats the ends of justice less than that of the lawyer, who often knowing the guilt of his client and all the circumstances of the crime, uses this knowledge entirely for the benefit of the prisoner, and, by reason of the information, probably gets an effectual means of defence. Yet his conduct is not looked upon as reprehensible, but would certainly be regarded as such if he announced in court that the man had confessed to him that he was guilty of the imputed crime.

In this country the doctor is not privileged as we have previously said, and this opinion has again been recently confirmed by the answer of counsel to the question of the Royal College of Physicians, London, which ran as follows: Has a medical practitioner any privilege with regard to secrets confided to him in the course of his practice analogous to the privilege as between a solicitor and client or otherwise? Answer: We are of opinion that there is no privilege attaching to statements made to a medical practitioner by his patient. Our profession, then, is not in any degree protected or supported by law, as from time immemorial the legal profession has been; nor has it that tacit protection which is extended to the priest. Yet it is no less true, as we know, that should a doctor disclose any fact to a third party which may affect the character or cause injury to the patient he would be liable to an action for defamation of character. There are pitfalls innumerable the moment we swerve from the golden rule of absolute reticence. And alas! it is also true that the most rigid adherence to this rule does not always bring safety to the practitioner, and indeed may sometimes land him in an awkward predicament. For example, let us take the hypothetical case instanced by Mr. Justice Hawkins at the trial already referred to in which he remarked it would be "monstrous cruelty" if the doctor did not keep silence in the criminal case which might come under his observation. Presuming such a case to occur, which it may do at any moment, and the doctor is faithful to his patient and does exactly as Mr. Justice Hawkins would have him do, says nothing about it and does the best he can for his patient. Notwithstanding this she dies from her self-inflicted injuries. No one knows of them but the doctor and his patient, and she is dead. He may properly certify the death as one from septicæmia. Possibly she may have consulted him about her condition before she was driven to commit the crime which ended her life; and rumour is busy, and suspicion is aroused, and the Public Prosecutor gets hold of the case. A necropsy reveals the injuries which presumably have caused death. Then the question arises, Who would be the more likely person to commit the crime, the patient or the doctor. The Public Prosecutor and the public may think the doctor the more likely, and he may possibly come to be tried for murder, and should such a case come before Mr. Justice Hawkins, would he say you have done a "monstrous cruelty" if you had informed upon this poor woman? In such a case, the doctor, according to the judge, deserves to be hanged if he does inform, and may certainly be hanged if he does not.

But to return to the protection of the patient, not only in this vexed question of criminal abortion, about the reporting of which lawyers and doctors both here and in America take such different views, arising doubtless from the laudable desire to stop the crime, and at the same time shield the patient, but many others in which the obstetrician has difficulty in deciding how to act. In cases of "concealment of pregnancy" I presume the medical man would be expected to

inform, but to what extent does it differ from that of self-inflicted abortion, and why should the law or we be less careful to protect the poor woman who, in the agonies of labour and great distress of mind, destroys or allows her child to die while coming or having just passed through the maternal passages, than she who has destroyed her child *in utero*? This is surely a legal and altogether arbitrary distinction.

Then there are the cases of pregnancy sometimes with abortion, in women out of wedlock, or where the wife has been separated from her husband for a considerable time. In no class of cases perhaps is it more necessary for the medical adviser to remain silent in the interest of the patient and for the protection of himself.

Perhaps the most common experience, and one in which it is most difficult to preserve the secret of the patient, is that in which the practitioner is sent for to see a servant in the employment of a client. Her mistress may or may not be suspicious regarding the nature of the illness, and has employed the practitioner not only to treat the servant but to tell her what is wrong. How should such cases be dealt with? It has been said in justification of breaking the confidence existing between doctor and patient in such cases, that the doctor is acting solely as the professional agent of the employer, and that he was sent for the special purpose of knowing in what condition she is and pays him his fee. In such cases there is no justification. Such a supposition is quite fallacious, wrong in principle, unjust, not in accordance with law, and would in many cases be actionable. In such circumstances it is always necessary not only to have the full permission of the patient to see and prescribe for her, but also permission to tell her employer what she suffers from.

No part of the practice of obstetrics and gynaecology requires more tact and prudence than the management of syphilis and gonorrhœa in married people. It must not be always taken for granted because a married woman has one or other of these diseases that the husband is the source of infection, and if not so, it would plainly be wrong to allow him to be exposed to the risk just as much as when the husband is suffering from such complaints, we must safeguard the wife; and this we endeavour to do effectively without breaking faith with the patient. The delicate question whether a woman should be told what she suffers from must be determined by the particular circumstances of the case, and whether it be in her interest and for her good that she should know. It sometimes is not. The aim in all such cases is to prevent disease, while at the same time the secret of the patient is kept. Should the practitioner think it his duty to break faith with his patient, he should feel perfectly certain that there is strong reason for doing so sufficient to have weight with both judge and jury. Scarcely less difficult is it to know how to act when such diseases occur in servants and employees, and in these cases the medical practitioner runs greater risk of an action-at-law should professional confidence be broken. I trust the time is not far distant when the practitioner will be freed from this responsibility by the compulsory notification of all contagious diseases.

But not only is the question of professional secrecy in relation to the law upon an unsatisfactory footing: the law itself as it at present stands is directly opposed to the very frequent practice of the obstetrician, notwithstanding the assurance of counsel given about two years ago to the Royal College of Physicians, London, "that the law does not forbid the procurement of abortion during pregnancy, or the destruction of the child during labour where such destruction of life is necessary to save the mother." But this is only the opinion of counsel, the law remains: and though the illegality of these operations may not be entertained in the law courts, still—"In the event of the death of the mother, the medical man exposes himself to a prosecution for a criminal offence." Why, then, should the law not be amended to run as it does in the Penal Code of the State of New York? "A person who with intent thereby to procure the miscarriage of a woman, unless the same is necessary to preserve the life of the woman or of the child with which she is pregnant, is guilty of abortion, etc."

After what has been said, it must, I think, be admitted that with the law on one side and the patient on the other, the

position of the obstetrician is in a very uncertain state of equilibrium, and that this condition of affairs calls for early readjustment. Whether the adoption of a law such as exists in America and France (and it has much to recommend it) should be made is a matter for serious consideration. But whatever may be done, the law should emphasise in some very decided way a patient's legal right of privilege which she can only waive, except—and the law should make the exceptions—in certain well-defined cases. It does so now in the notification of infectious diseases, it may in the future do so in the case of contagious diseases, and it ought to specify in other cases what the doctor must reveal.

As things now are, the public generally think that professional reticence is merely the fastidious rule of a fastidious profession, contrary, as they often signify, to common sense. But, and until there is a clearer understanding between the law and the medical profession, and something definite achieved in this direction, the obstetrician and medical practitioner should bear in mind that it is the duty of the law to detect crime, that the Public Prosecutor is alone responsible for its proper investigation, and that the duty of the physician is simply to his patient. For his own protection, about which the law thinks nothing, the general practitioner at least should never induce premature labour without consultation with another medical man, that in all cases of suspected criminal abortion he should safeguard himself by calling in as early as possible another independent medical witness, and that never under any circumstances whatever should he be induced to examine a woman without her full consent, and preferably in the presence of witnesses.

And now the last few moments which end my presidency are gone, and it only remains for me to reiterate my gratitude for your kindness, and for the great honour you have done me. In my successor you will find not only a much more worthy President, but a familiar friend; one already accustomed to the duties of this chair, and one whom we all delight to honour, not only for the work he has done for this Society, but for his high standing as a gynaecologist, obstetrician, and teacher.

REFERENCE.

1 BRITISH MEDICAL JOURNAL, 1896, i, p. 871.

SOME OBSERVATIONS ON THE COMPOSITION OF HUMAN MILK.

By ALFRED H. CARTER, M.D., F.R.C.P.,
Professor of Medicine in Mason College, Birmingham;

AND

H. DROOP RICHMOND, F.I.C.

A TRUSTWORTHY estimate of the average composition of healthy human milk is most desirable for two reasons. In the first place it affords a standard by which we may judge of the quality of a mother's milk in cases where such milk disagrees with her infant; and in the second place it provides us with a standard by which we may adjust the composition of an artificial food for an infant during the suckling period. The table on page 200 represents the results of analysis of 94 samples of human milk. They were derived almost entirely from women admitted into the lying-in department of the Birmingham Workhouse Infirmary. With 7 exceptions all the samples were taken at some time within the puerperal month. There is every reason to believe that by this time human milk attains a composition which does not vary to any important extent during the later period of normal lactation.

The methods of analysis adopted were as follows:

TOTAL SOLIDS (WATER) AND ASH.

Five grammes were weighed into a tared platinum basin and evaporated to dryness on the water bath; the drying was continued in a water oven till the weight was practically constant. The residue was weighed as total solid matter, and the loss considered as water. The residue was then carefully ignited over a small flame till a white ash was left; it was found that the organic matter burnt easily if the basin was not covered during the ignition and the ash was not fused.

FAT, PROTEIDS, AND SUGAR.

Five grammes were weighed into a beaker and diluted with 50 c.cm. of distilled water; 2 c.cm. of a solution of copper sulphate (65 g. per litre), and a tenth normal solution of caustic soda dropped in, till the precipitate settled rapidly in curdy flakes; after some hours' repose, the clear liquid was decanted into a Gooch crucible, and the precipitate was then washed, first by decantation and then on the crucible with distilled water by means of reduced pressure. The crucible and its contents were then dried in the water oven till the precipitate dried in flakes; the crucible was placed in a small beaker, filled with ether, and left to macerate for twenty-four hours, at the expiration of which time it was submitted to a thorough washing with ether, the beakers and stirring rods being also rinsed with ether. This treatment was again repeated after a further drying. The crucible was then dried in the water oven till constant in weight; it was next ignited, at first gently, and finally strongly, and the difference between the weight after drying and that after ignition was taken as the proteids. This is the well-known Ritthausen method slightly modified in detail.

The combined ethereal solutions were evaporated in a small flask, and the residue, after heating in the water oven till the weight was constant, was considered as fat. This was examined in Zeiss's butyro-refractometer at a temperature of 35° C. to obtain the refractive index. In several cases the fat was also estimated by the Adams, Werner-Schmidt, or Gerber methods, and no appreciable difference was observed.

The filtrate from the precipitate produced by copper sulphate was used in several cases for the determination of the sugar by weighing the copper oxide produced on boiling with Fehling's solution. Estimations were also made by polarising the filtrate obtained by adding acid mercuric nitrate, or an acetic acid solution of picric acid to the milk. In all the analyses reported, however, the results for sugar were taken by difference; the reason for this will be discussed later.

Our methods differ only in detail from those adopted by Leeds; they give excellent results with cow's milk, and here the sugar deduced by difference agrees well with that estimated by Fehling's solution or by polarisation. In one particular we are totally at variance with him, as he finds that his analyses add up to 100 per cent. when all the constituents are directly determined; we find that ours are seriously below that total, when we attempt to take our estimated figures for lactose to represent the sugar. We will refer again to this.

We have noticed the fact recorded by Leeds that the fats are often, though not always, tinted green: this we find to be due to the presence of copper, and appears to be caused by the presence of free fatty acids in the fat. We find that the copper is easily removed from the green fats by shaking with dilute hydrochloric acid, and the fat then contains free fatty acid; the fat obtained in other processes also contains free fatty acid, and a similar colour may be obtained when a neutral fat (as that of cow's milk) receives an addition of a fatty acid.

The following table shows the amount of copper found in some of the fats, together with our notes of the colour:—

Serial Number.	Percentage of CuO in Fat.	Remarks.
19	2.80	Very deep green.
7	1.27	Very green.
12	0.87	Green.
15	0.62	Green.
16	0.30	Slight green.

The colour is directly proportionate to the percentage of copper in the fat; all figures are corrected by subtracting the percentage of copper oxide.

From the table the following arithmetical mean may be calculated:

Specific gravity	... 1031.3	Sugar	... 6.59
Water	... 88.04	Proteids	... 8.97
Fat	... 3.07	Ash	... 0.26